U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 30 April 2007

In the Matter of:

B.H., Survivor of C.H.,
Claimant

Case No.: 2005-BLA-5013

v.

S&H MINING, INC.,
Employer

OLD REPUBLIC INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson, Program Director.
Stone Mountain Health Services
Saint Charles, Virginia
For the Claimant (Miner's Claim)

Christie Hutson, Representative
Reachs Community Health Center
LaFollette, Tennessee
For the Claimant (Survivor's Claim)

Debbie Fulton, Esq.
Knoxville, Tennessee
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that she is the surviving dependent of a Miner whose death was due to pneumoconiosis.

I conducted a consolidated hearing on this claim and the accompanying Miner's claim on March 29, 2005, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director of the Office of Workers Compensation Programs (OWCP), was not represented at the hearing. The Daughter of the Claimant and the Miner was the only witness. Transcript ("Tr.") 18-24. Director's Exhibits ("DX") 1-78, Claimant's Exhibits ("CX") 1-2 and Employer's Exhibits ("EX") 1 and 2 were admitted into evidence without objection. Tr. 9-12. The Employer objected to the diagnosis of coal workers' pneumoconiosis by a nurse practitioner contained in the Director's Exhibits, without reference to a particular exhibit number; I ruled that the qualifications of the nurse went to the weight to be given to the report, rather than its admissibility. Tr. 8-9. However, review of DX 19 discloses that the Miner submitted both the nurse practitioner's treatment notes, and her letter of support for the black lung claim. I have considered only the treatment notes, as the letter of support for the claim was not designated on the Claimant's Evidence Summary Forms. The Claimant objected to Employer's Exhibit 3 as exceeding the limitations on medical evidence contained in the rules for review of an autopsy; it was admitted over the Claimant's objection as being within the allowed number (two) of "initial" medical reports. *See* the Employer's Evidence Summary Form for the Survivor's claim. Discussion at the close of the hearing revealed that to consider all admitted evidence in both claims would result in exceeding the limitations on medical evidence contained in the current regulations. The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004). The record was held open after the hearing to allow the parties to submit revised Evidence Summary Forms to distinguish between the evidence to be considered in the Miner's and the Survivor's claims. Tr. 25-32.

This decision addresses only the Survivor's claim. I am issuing a separate decision on the Miner's claim. In reaching my decision, I have reviewed and considered the entire record, including all exhibits unless otherwise noted, the testimony at the hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed her claim for Survivor's benefits on September 12, 2003. DX 49. Her claim was consolidated with a claim filed by the Miner during his lifetime. On August 2, 2004, the District Director, OWCP, issued a Proposed Decision and Order denying the Survivor's claim. DX 68. The Claimant requested a hearing via letter dated August 10, 2004. DX 71. Both claims were referred to the Office of Administrative Law Judges on September 28, 2004. DX 74, 75.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). A surviving spouse is entitled to benefits if the miner died due to pneumoconiosis which arose out of coal mine employment. See 30 U.S.C. § 901; 20 CFR §§ 718.205 and 725.212(a)(3) (2006). The Claimant must first establish that the miner suffered from pneumoconiosis. *See Trumbo v. Reading Anthracite Co.,* 17 B.L.R. 1-85 (1993).

ISSUES

The issues contested by the Employer, or by the Employer and the Director are:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether his death was due to pneumoconiosis.

DX 75; Tr. 5-7. The Employer withdrew its contest of whether the Miner was in fact a miner, and whether it is the Responsible Operator. Although the Employer contested the Miner's alleged 46 years of coal mine employment, it stipulated to 30 years of coal mine employment. Tr. 6, 15. The Employer reserved its right to challenge the statute and regulations. Tr. 6-7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Hearing Testimony

The Miner testified at the prior hearing on the topic of his smoking history. DX 39: 32-34. He stated that he quit smoking about one year before the hearing. He was unable to recall when he began smoking but stated that he smoked 7 to 8 cigarettes per day when he did smoke.

The Miner and the Claimant married in 1958. DX 53.

The Miner died on June 4, 2003.

The Daughter of the Claimant and the Miner testified at the hearing held before me. She testified that her father worked more than 30 years in the coal mines. As noted above, the Employer stipulated to 30 years of coal mine employment, Tr. at 6, 15, DX 39: 9, and the employment history and Social Security records support this stipulation. DX 2, 3. The Daughter stated that her father worked many different jobs that caused him to come home very dirty. Her father retired because he fell ill with pneumonia. He began smoking at the age of 14 or 16 years, and quit approximately six months before his death, at which time he was smoking at a rate of approximately one-half to one pack per day. She testified that he would cough up a black substance and did so when he died. She stated that her mother never remarried after her father's death.

The Miner's last coal mine employment was in Tennessee. DX 2. Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc)*.

Medical Evidence

When a Miner's claim and a Survivor's claim are consolidated, the parties must designate which evidence is to be considered in each claim in accordance with the limitations found in 20 CFR § 725.414. *Keener v. Peerless Eagle Coal Co.*, BRB No. 05-1008 BLA, ALJ No. 2004-BLA-6265, electronic slip op. (PDF) at 9-11 (BRB Jan. 26, 2007). As noted above, the parties have submitted separate Evidence Summary Forms for the Miner's and the Survivor's claims, designating which evidence they wish to be considered in each claim. Where necessary to avoid considering excessive medical evidence, I have referred to the parties' Evidence Summary Forms in selecting which evidence to consider in each claim.

Autopsy

An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. Greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides. *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir. 1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197, 200 (3d Cir. 1982); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991); *Similia v. Bethlehem Mines Corp*., 7 B.L.R.1-535, 1-539 (1984); *Cantrell v. U.S. Steel Corp*., 6 B.L.R. 1-1003, 1-1006 (1984). An autopsy report may be given greater weight than x-ray reports. *Griffith v. Director, OWCP*, 49 F.3d 184, 187 (6th Cir. 1995), citing *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir.1990).

Dr. Michael Dyer performed an autopsy on the Miner and prepared a report on his findings and final diagnosis. DX 41, DX 55. According to the web-site of the American Board of Medical Specialties, Dr. Dyer is board-certified in Anatomic and Clinical Pathology. In his Autopsy Summary, Dr. Dyer stated:

> The patient is a 64-year-old male who has a history of 'black lung disease' and transitional cell carcinoma of the urinary bladder. The patient expired on 6/4/03 at 10:10 a.m. and an autopsy limited to the lungs was requested.
>
> Pertinent findings at autopsy include pneumoconiosis demonstrating birefringent material consistent with silica when examined with polarized light. These lesions are identified throughout both lungs. One also observes metastatic transitional cell carcinoma, grade 3 involving both lungs along with severe emphysematous changes. Bronchopneumonia is also identified in the left lower lobe and the right upper lobe.

> The presence of fibrotic nodules containing anthracotic macrophages, fibrosis and birefringent material indicate severe pneumoconiosis compatible with exposure to dust such as seen in miners (black lung). The presence of large numbers of anthracotic pigment containing macrophages is very suspicious of exposure to coal dust Severe emphysematous changes are identified.
>
> This case was reviewed by Dr. David Birdwell, and he agrees with the stated diagnosis.[1]

DX 55: 3.

In the narrative autopsy report, Dr. Dyer recited additional pertinent medical history, including black lung, COPD, congestive heart failure and deep venous thrombosis of the left lower leg. Dr. Dyer described the Miner's lungs and noted that each had a black external appearance. When he sectioned the lungs, cut surface showed several bilateral nodules varying from 0.4 to 3.0 cm in diameter, and from a grayish-pink appearance to black fibrotic nodules. There were areas of consolidation in the right upper lobe and left lower lobe. Sections also revealed areas of emphysematous changes. Upon microscopic examination, Dr. Dyer stated that sections of both lungs revealed "scattered fibrotic nodules throughout the lungs containing abundant anthracotic histiocytes with fibrosis." The nodules measured up to 0.5 cm in diameter. Results of examination of the fibrotic anthracotic nodules with polarized light were consistent with silica. Emphysematous changes, and nodules of metastatic carcinoma were also demonstrated. Dr. Dyer stated that "[t]he presence of fibrotic nodules containing anthracotic macrophages, fibrosis and birefringent material indicated pneumoconiosis compatible with exposure to dust such as seen in miners." His final anatomic diagnoses were:

> 1. Clinical history of transitional cell carcinoma of urinary bladder.
> 2. Metastatic transitional cell carcinoma … bilateral lungs with hilar lymph node metastasis.
> 3. Pneumoconiosis, bilateral, severe, with large numbers of anthracotic macrophages, consistent with coal worker's pneumoconiosis.
> 4. Emphysematous changes, bilateral, severe.
> 5. Bronchopneumonia, bilateral.

DX 55: 2.

Dr. Joseph Tomashefski reviewed the Miner's medical records, autopsy slides and autopsy report on behalf of the Employer. DX 57. Dr. Tomashefski is board-certified in Anatomic and Clinical Pathology. In his report dated June 16, 2004, Dr. Tomashefski recited the history of the Miner's diagnosis and treatment for bladder cancer, as well as the complications he experienced during his last year of life. He also took into account the Miner's history of chronic obstructive pulmonary disease, noting his 50 pack-year history of smoking, and 44 years of coal

[1] Under cover of letter dated April 6, 2005, the Employer objected to the reference to Dr. Birdwell, arguing that the Claimant's reference to his concurrence on the Evidence Summary Form constituted an attempt to offer two expert opinions on the autopsy evidence, thus exceeding the limitations in the regulations. As there is no separate report by Dr. Birdwell, however, I overrule the objection. Nonetheless, I give no added weight to Dr. Dyer's report because of Dr. Birdwell's apparent concurrence.

mine employment. Dr. Tomashefski stated his opinion on the cause of the Miner's death as follows:

> Based upon my review of the medical records and the slides of [the Miner's] lungs and lymph nodes, it is my opinion that he had disseminated, metastatic, transitional cell carcinoma of the urinary bladder. It is also my opinion that he had severe, predominantly panacinar emphysema and severe acute bronchopneumonia. Based on the presence of a few coal macules and micronodules, it is also my opinion that [the Miner] had very mild simple coal works' pneumoconiosis.
>
> Within reasonable medical certainty, metastatic transitional cell carcinoma of the urinary bladder is the underlying cause of [the Miner's] death. Acute bronchopneumonia is the immediate cause of death, and severe emphysema is a contributory cause of death.
>
> In my opinion, [the Miner's] simple coal workers' pneumoconiosis is of too mild a degree to have caused him any respiratory symptoms, respiratory impairment or to have been a cause of, or a contributory factor in, his death. The mild nature of [the Miner's simple coal workers' pneumoconiosis is supported by the B-readers' interpretations of his chest x-rays as being negative for changes of pneumoconiosis or as showing small round opacities of low profusion. The mild nature of [the Miner's] simple coal workers' pneumoconiosis is also suggested by the chest CT scan reports which do not describe parenchymal nodular opacities.
>
> It is also my opinion that [the Miner's] mild simple coal workers' pneumoconiosis, coal mine employment, or coal dust exposure neither caused nor contributed to his bladder carcinoma or diffuse panacinar emphysema. Emphysema is present well beyond the few pneumoconiotic lesions that are present in [the Miner's] lung tissue. In my opinion, within reasonable medical certainty, [the Miner's] death was totally unrelated to his coal mining occupation or his mild simple coal workers' pneumoconiosis.
>
> In my opinion, [the Miner's] carcinoma of the bladder and his emphysema were the result of heavy and sustained exposure to tobacco smoke over approximately 50 years.

DX 57: 3-4 of the report.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. X-ray readings from treatment records are not subject to the limitations.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties. [2] Qualifications of physicians are abbreviated as follows: B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03/05/01			DX 18 Coffey Questionable mass and diffuse interstitial scarring
04/06/01			CX 2 Crater Hyperinflation.
10/23/01	**DX 18 Ahmed BCR/B ILO Classification 1/1**	[3]	DX 18 Coffey Increasing hilar region and no active infiltrates.

[2] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

[3] The Employer listed a rebuttal reading of this x-ray by Dr. Dahhan, DX 38, in its Evidence Summary Form. I could not find any reading of this x-ray by Dr. Dahhan anywhere in the file. In any event, I note that Dr. Ahmed is better qualified to read x-rays than Dr. Dahhan, as he is both a radiologist and a B reader, while Dr. Dahhan is only a B reader. *See also* note 4.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/13/01	**DX 9 Baker B ILO Classification 1/0**	**DX 19 Wiot BCR/B[4]**	**DX 9 Sargent BCR/B Quality Reading – Film Quality 2 (Acceptable)**
12/14/01			DX 18 Coffey COPD
01/09/02	**DX 18 (DX 1) Miller BCR/B ILO Classification 1/2**	**DX 19 Wiot BCR/B[5]**	
02/25/02		**DX 38 Wiot BCR/R ILO Classification 0/1** **DX 16 Dahhan B ILO Classification 0/0**	
03/12/03			EX 2 Foster, COPD, no acute disease seen

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains reports of two CT scans of the Miner's chest.

Dr. Thomas Hall performed a CT scan on the Miner's lungs on November 29, 2001. DX 18. He noted that the Miner's lungs were over inflated and assessed COPD.

Another CT scan was performed while the Miner was in the hospital for a deep vein thrombosis from March 12-17, 2003. EX 2. There was no evidence of a pulmonary embolus, but there was evidence of COPD in the lungs.

[4] On its Evidence Summary Forms, under chest x-ray rebuttal evidence, the Employer listed readings of three x-rays by Dr. Dahhan on January 24, 2003, to be found in DX 38, as evidence it would offer. However, the only report from Dr. Dahhan bearing that date in DX 38 is a letter from Dr. Dahhan stating that mycoplasma can cause false positive readings on chest x-rays. The letter does not identify which x-rays Dr. Dahhan was referring to, and no x-ray readings are attached to the letter; nor did I find Dr. Dahhan's readings of any of the listed x-rays anywhere in the record. Dr. Dahhan's reading of the x-ray taken on October 23, 2001, would be admissible. However, admission of his readings of the November 13, 2001 and January 9, 2002 x-rays, or consideration of his opinion based on them, would violate the evidentiary limitations in the rules, as the Employer is allowed only one rebuttal reading of each x-ray reading offered by the Claimant or the Director, and the Employer introduced readings of both of those x-rays by Dr. Wiot. For this reason, I have not considered Dr. Dahhan's January 24, 2003 letter in reaching my decision.

[5] *See* note 4.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. The other studies were administered during treatment, and are not subject to the limitations. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 2 04/06/01 Crater	62 69"	1.04	2.21	47%		Yes	Severe obstruction.
DX 18 10/18/01 Narayanan	**62 71"**	**1.37**	**3.57**	**38%**	**40.5**	**Yes**	**Severe obstruction and low vital capacity, possibly from a restrictive defect.**
DX 18 10/23/01 Physician not identified	62 70"	1.15 1.23	2.97 3.00	39% 41%		Yes Yes	Severe obstruction and low vital capacity possibly due to restriction. "No acceptable maneuvers, interpret with care."

[6] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 69" to 71", I have taken the mid-point (70") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[6]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 9 11/13/01 Baker	**62 69"**	**1.17**	**4.08**	**29%**	**32**	**Yes**	**Severe obstructive defect.** **Dyspnea. Miner failed to completely exhale on most tracings.** **DX 9 Dr. Michos found the vents acceptable, but suboptimal MVV performance.**
DX 16 02/25/02 Dahhan	**63 175 cm (69")**	**1.18 1.28**	**2.87 2.99**	**41% 43%**	**24 36**	**Yes Yes**	**Obstructive abnormality.**
DX 37 10/24/02 Narayanan	**63 71"**	**1.04**	**3.61**	**29%**	**30.0**	**Yes**	**Severe obstruction and low vital capacity, possibly from a restrictive defect.**

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. The other study was administered during treatment, and is not subject to the limitations. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise

blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
CX 2	04/06/01	Crater	49.6	64.3	No	
DX 9	**11/13/01**	**Baker**	**47**	**71**	**No**	**Mild resting hypoxemia**
DX 16	**02/25/02**	**Dahhan**	**44.2** **40.5**	**63** **74**	**No** **No**	**Exercise was terminated due to fatigue**

Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, and whether pneumoconiosis caused the miner's death. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). The cause of death must be proved by competent medical evidence. 20 CFR § 205(c) (2006). The record contains the following medical opinions relating to the Survivor's claim.

Treatment Records

The Miner was treated by various doctors and nurse practitioners at a primary care clinic from 1995 to 2001. DX 18. A treatment note by a nurse practitioner dated July 19, 1995, indicates that the Miner, who was still working in the mines, had been told by the Department of Labor that a recent x-ray indicated that he had black lung and should work in a low dust area. Chest examination revealed congested lungs with scattered wheezes and rales. The Miner was diagnosed with black lung and COPD (chronic obstructive pulmonary disease). He was prescribed medication, and referred to a lawyer to consult about his legal options. Then there is a gap in the records until May 2000, when the Miner complained of and was treated for an unrelated medical problem. In 2001, the Miner was seen three times in late February and early March, and four times between mid-October and mid-December, for bronchitis and dyspnea along with COPD. Examinations revealed rhonchi, wheezes and decreased breath sounds.

The Miner was referred to Dr. Glenn D. Crater for evaluation of his difficulty breathing on April 6, 2001. CX 2. According to the American Board of Medical Specialties, Dr. Crater is board certified in Internal Medicine, Pulmonary Disease, and Critical Care. Dr. Crater took the Miner's medical, family and social histories, and performed a physical examination, chest x-ray, pulmonary function studies and arterial blood gas studies. Dr. Crater recorded that the Miner worked in a coal mine, and started smoking at age 16, a pack a day until a couple of months

before the examination, and continuing to smoke intermittently. The chest examination revealed prolonged expiratory phase, with no rhonchi or wheezes. The pulmonary function studies revealed severe obstruction. Chest x-ray revealed severe hyperinflation. Dr. Carter diagnosed severe emphysema, and prescribed medication. Dr. Crater saw the miner again on May 18, 2001 for follow-up. The chest examination revealed wheezes bilaterally but good air movement. Dr. Crater's impression was severe emphysema with mild exacerbation.

The Miner submitted a treatment note dated December 17, 2001, and a report dated April 5, 2002, by Kellie Brooks, a nurse practitioner. DX 18. I have considered only the treatment note, as the Claimant did not designate the report as one on which she relies in her Evidence Summary Forms. In the treatment note, Ms. Brooks reported that the Miner worked in the coal mines for 27 years, having stopped in May 2001 due to his health. Additionally, she noted the Miner's symptoms, medical, family and social histories. His x-ray revealed simple pneumoconiosis and pulmonary function studies revealed severe obstruction. Ms. Brooks diagnosed coal workers' pneumoconiosis and COPD.

Dr. Mark G. Bowles was the Miner's urologist. According to the website of the American Board of Medical Specialties, Dr. Bowles is board-certified in Urology. According to a report he prepared at the request of the Claimant's representative, recited below, he first saw the Miner on June 5, 2000. The Claimant introduced some of Dr. Bowles' progress notes from 2002 and 2003 into evidence in CX 1. Most of the notes pertain to his treatment of the Miner for bladder cancer. His notes also reflected the Miner's severe COPD and black lung. The note for February 2, 2003, recorded that the Miner had had radiation therapy, but only one chemotherapy because of significant COPD. Dr. Bowles noted that the Miner had been to the emergency room on January 25, 2003 for shortness of breath. The Miner had been smoking more, and Dr. Bowles encouraged him to stop smoking. On February 28, 2003, Dr. Bowles reported that the Miner had been back in the hospital under the care of Dr. Crater the previous week with worsening COPD and congestive heart failure. Dr. Bowles went on to state, "Overall he looks to be worsening, especially from a cancer and cardiovascular and pulmonary status." By April 11, 2003, the Miner was doing much worse. Dr. Bowles told the Miner he could expire at any time. The Miner was told he could return to see Dr. Bowles whenever he needed to.

The Miner was hospitalized under the care of Dr. Charles Bruton from February 20 to 25, 2003, for increased shortness of breath. DX 37; CX 2. According to the discharge report, the Miner had been a heavy smoker who stopped about eight weeks before. The report also noted that he was receiving black lung benefits, and was using supplemental oxygen. After receiving medication in the hospital, the Miner's discharge diagnoses were chronic obstructive pulmonary disease, acute exacerbation, acute on chronic; coal workers' pneumoconiosis; and recurrent carcinoma of the bladder. On discharge, he was returned to the care of Dr. Perry, who was identified in hospital records as the Miner's primary care physician. Dr. Perry's records were not offered into evidence by any party.

The Miner was hospitalized from March 12-17, 2003, under the care of Dr. Jerry Foster due to a deep vein thrombosis. EX 2. According to the web-site of the American Board of Medical Specialties, Dr. Foster is board-certified in Internal Medicine and Medical Oncology. The Miner was treated for the thrombosis, received chemotherapy for his bladder cancer, was seen by a pulmonary physician for management of his COPD, and was seen by cardiology for chest pain during his hospital stay. The pulmonologist, Dr. Dryzer, noted the Miner's history of

smoking and coal mine work. Dr. Dryzer's diagnoses included COPD with exacerbation, and history of coal workers' pneumoconiosis. He ordered a CT scan to check for a pulmonary embolus. As noted above, the CT scan did not reveal a pulmonary embolus, but did show COPD. Discharge diagnoses were left lower extremity deep vein thrombosis; stage IV transitional cell carcinoma of the bladder; and severe chronic obstructive pulmonary disease.

Death Certificate

The record contains the death certificate for the Miner signed by Dr. Foster. DX 54. It lists the immediate cause of death as metastatic transitional cell carcinoma of the bladder and lymph nodes. Additionally, Dr. Foster listed COPD, lower extremity deep vein thrombosis and black lung as significant conditions contributing to the Miner's death.

Opinions Obtained in Connection with the Claim for Benefits

Dr. Baker

Dr. Baker examined the Miner on behalf of the Department of Labor on November 13, 2001. DX 9. According to the web-site of the American Board of Medical Specialties, Dr. Baker is board-certified in Internal Medicine and Pulmonary disease. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Miner worked in the mines for 44 years. He reported a smoking history of approximately one pack per day for fifty years, currently smoking three cigarettes per day. The chest examination revealed wheezing upon inspiration and expiration. Dr. Baker read the x-ray as showing coal workers' pneumoconiosis, 1/0. The pulmonary function test showed severe obstructive impairment. The arterial blood gas study revealed mild hypoxemia at rest. Dr. Baker diagnosed coal workers' pneumoconiosis based upon the abnormal chest x-ray and coal dust exposure (clinical pneumoconiosis); COPD with severe obstructive defect based upon the pulmonary function studies; chronic bronchitis based upon history of cough, sputum production and wheezing; and hypoxemia based upon the arterial blood gas studies. He attributed the clinical pneumoconiosis to coal dust exposure, and all of the other diagnoses to coal dust exposure and cigarette smoking. Dr. Baker found that the Miner had severe impairment in function based on his lungs, which he attributed to all of the previously listed diagnoses. On an attachment to the examination results, Dr. Baker indicated that the Miner was totally disabled due to cigarette smoking and coal dust exposure.

Dr. Dahhan

Dr. Dahhan examined the Miner on behalf of the Employer on February 25, 2002. DX 16. Dr. Dahhan is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, electrocardiogram, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Miner worked in the mines for 46 years. He reported a smoking history of one fourth to one half of a pack per day for approximately 40 years. The chest examination showed bilateral expiratory wheeze with no crepitation or pleural rubs. Dr. Dahhan read the x-ray as showing hyperinflated lungs consistent with emphysema with bullae formation, but otherwise clear "with no pleural or parenchymal abnormalities consistent with pneumoconiosis." The pulmonary function test showed obstructive abnormalities. Carboxyhemoglobin was 4.4%,

indicating that the Miner was smoking a pack per day. Dr. Dahhan said there was insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination and pulmonary function testing, and negative x-ray reading. He diagnosed chronic obstructive pulmonary disease. He said that the Miner did not retain the capacity to continue his previous coal mine work or a job of comparable physical demand because of his obstructive disease. Additionally, Dr. Dahhan opined that the Miner's obstructive airway disease was due to smoking, and not related to, caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis. He said that the obstructive defect "was not caused by the inhalation of coal dust since he has not had any exposure to coal dust for over a year." Dr. Dahhan specifically stated that the Miner's obstructive defect is severe enough to be disabling, "a finding that is rarely ever seen secondary to the inhalation of coal dust per se as reported by Drs. Lapp and Associates …" In addition, he stated the Miner's condition was responsive to bronchodilators, and that he was being treated with bronchodilators, which is inconsistent with a diagnosis of coal workers' pneumoconiosis.

Dr. Bowles

As noted above, Dr. Bowles was the Miner's treating Urologist. He prepared a report dated August 27, 2004, at the request of the Claimant's representative. In his report he stated,

> I first met [the Miner] at our office on 6/5/00 as a consultant from Dr. Coffey in Oneida, Tennessee. [The Miner] was diagnosed at surgery on 7/18/02 with resection of a bladder tumor. Pathology report revealed an aggressive and poorly differentiated transitional cell carcinoma of the bladder. At that time, his chest x-ray and medical history were consistent with coal workers pneumoconiosis and COPD. Because of his significant lung disease, he was not a candidate to undergo standard therapy with a major operation such as a radical cystectomy and ileal conduit, He nor I believed he would survive the surgery. Unfortunately, this type of surgery would yield the best chance for cure and survival. Therefore, since he could not have this surgery, we were relegated to doing external beam radiation therapy to try for palliative control of his bladder cancer with only a small chance of cure. Unfortunately he only tolerated one treatment of simultaneous chemotherapy, further decreasing his chance for cure. I have reviewed his death certificate and autopsy findings. It is clear to me that he died from metastatic transitional cell carcinoma of the bladder, based on the autopsy report. He had significant transitional cell carcinoma in his lungs with pneumoconiosis and emphysema and bronchial pneumonia. I would presume, although I am not an expert, that he likely developed bronchial pneumonia in the last several days of his life as he was in a weakened state. At the time of his [diagnosis] of aggressive bladder cancer, he did not have metastatic cancer of the bladder to the lungs. He obviously developed this later. [The Miner's] lung disease at the time of his diagnosis of bladder cancer included pneumoconiosis and COPD. Because of his severe lung disease, I could not offer him the best chance for cure (radical cystectomy). I feel at least in part his pneumoconiosis contributed to his death by reducing his lung function and not permitting us to proceed with possible curative therapy for his bladder carcinoma.

CX 1.

Dr. Pietragallo

Dr. Pietragallo reviewed the Miner's medical records and provided a report dated August 18, 2004, which the Employer submitted in rebuttal to Dr. Bowles' report. EX 1. Dr. Pietragallo is board certified in Internal Medicine and Hematology. Dr. Pietragallo recited that the Miner presented to the hospital with hematuria on July 17, 2002. He noted a 50 year smoking history, and a clinical diagnosis of COPD supported by chest x-ray and CT reports that did not specifically mention pneumoconiosis. Surgery and pathology revealed a high grade carcinoma with muscular invasion. CT scan at the time did not show any obvious metastases. The Miner's medical condition, especially his COPD, rendered him a poor candidate for radical surgery, but he was thought to be a suitable candidate for combined radiation therapy and chemotherapy. A follow up CT scan of the abdomen and the pelvis less than seven months later revealed large pelvic nodal metastases. The Miner deteriorated further over the next few months with complications, and died on June 4, 2003. Dr. Pietragallo went on to state:

> The rather rapid development of advanced metastatic disease less than 7 months after the diagnosis of bladder cancer indicates the overwhelming likelihood and extremely high probability that occult metastatic disease was indeed present in July, 2002. Given the circumstance of para-aortic and large pelvic node metastases visible on CT scan 6-7 months after presentation, there is only a remote probability, in my opinion less than 15 percent, that occult metastases were not indeed present at the time of the initial diagnosis of bladder cancer. Therefore, I can state with very reasonable medical certainty that [the Miner] would very probably, with greater than 85 percent likelihood, have died of metastatic bladder cancer even if bladder surgery could have been performed. Moreover, in my review of the medical records and autopsy findings, chronic obstructive lung disease related to cigarette smoking rather than pneumoconiosis caused [the Miner's] lung disease.

EX 1.

Dr. Fino

Dr. Gregory Fino reviewed the Miner's medical records on behalf of the Employer on several occasions. Dr. Fino is board certified in Internal Medicine and Pulmonary Disease, and a B reader. On February 21, 2005, he prepared a report submitted by the Employer in the Survivor's claim. EX 3. He referred back to his previous reports dated February 19, 2003, April 15, 2003 and September 3, 2004, and stated that the majority of chest x-ray readings were negative for pneumoconiosis.[7] Taking all of the information into consideration, he said it was his opinion that the Miner's obstructive disease was due to smoking. Even had he assumed that legal pneumoconiosis was present, he "did not believe that any reduction in the FEV1 due to coal mine dust inhalation caused, contributed to, or participated in any disability." For this report, Dr. Fino reviewed additional medical information regarding the Miner's treatment for bladder cancer and other conditions from July 17, 2002, until the Miner's death, including the autopsy from June 4, 2003. He also reviewed Dr. Bowles' and Dr. Pietragallo's opinions described

[7] Only the report dated February 21, 2005, has been considered in the Survivor's claim. Two of the three earlier reports were offered into evidence and considered in the Miner's claim. *See* the Employer's Evidence Summary Forms.

above. He prepared charts of the objective findings he had reviewed for all of the reports, including pulmonary function, blood gases and chest x-ray readings, as well as reported occupational and smoking histories.

Dr. Fino agreed with Dr. Bowles that the Miner did not have the respiratory capacity to undergo radical bladder surgery to attempt a cure. He said it was too speculative to say that had the Miner had the surgery, he would not have developed metastatic cancer. He went on to state:

> The real issue in this case is whether or not the patient's disabling respiratory impairment was due to coal mine dust. This is the issue because there is no doubt in my mind that this man's pre-existing, disabling pulmonary impairment was a significant contributing factor in his death. There is also no doubt in my mind [that] this man's pre-existing, disabling respiratory impairment precluded him from having bladder surgery. Again, I cannot state with reasonable medical certainty that this patient would not have developed metastatic bladder cancer had he had the surgery.

Dr. Fino went on to state, that even if he assumed that the bladder surgery would have prevented spread of the cancer,

> … the bottom-line here is that his pre-existing lung disease was not related to coal mine dust. In fact, the pre-existing disabling respiratory impairment was related to smoking. As I stated in previous reports, it is my opinion that this man would have been as disabled as I found him in 2003 and 2004 had he never worked in the mines. Therefore, it was a smoking-related pulmonary disability … that prevented him from having his bladder surgery …
>
> Even if I assume that simple coal workers' pneumoconiosis was present as noted by the prosector during the autopsy, it is still my opinion – based on my analysis of the medical information from my previous reports – that his functional impairment was due to cigarette smoking. I do not believe that coal mine dust inhalation played a clinically significant role in his disability.
>
> Therefore, even assuming that simple coal workers' pneumoconiosis was present, I can state with a reasonable degree of medical certainty that coal mine dust inhalation did not cause, contribute to, or hasten his death. It is my opinion, with a reasonable degree of medical certainty, that this man would have died as and when he did had he never stepped foot in the coal mines.

EX 3.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of

coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Miner's medical records indicate that he has been diagnosed with pneumoconiosis, as well as chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Miner filed his claim after January 1, 1982, and he died after March 1, 1978. There is no record of any biopsies taken during the Miner's lifetime. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must

consider the autopsy, the chest x-rays and the medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001); *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). In his autopsy report, Dr. Dyer described the appearance of the lungs, as a whole and after he sectioned them. He also performed both macroscopic and microscopic examination of the lungs. He opined that the Miner's lungs showed severe coal workers' pneumoconiosis, although he did not make a finding of complicated pneumoconiosis or progressive massive fibrosis. He documented the observations supporting his diagnosis. Dr. Tomashefski reviewed Dr. Dyer's report, viewed autopsy slides, and concurred that the autopsy evidence showed at least mild simple coal workers' pneumoconiosis. In this case, the autopsy provides conclusive evidence that the Miner had pneumoconiosis. Both pathologists agreed on this point, although they characterized its severity differently. I find that the Claimant has established that the Miner had clinical pneumoconiosis based on the autopsy results.

Because the autopsy provides the best evidence as to the presence of clinical pneumoconiosis, there is no evidence in the record which discredits it. Nonetheless, as the physicians who gave opinions during the Miner's lifetime relied on the x-ray evidence, it should also be addressed. X-rays of the Miner's chest were interpreted to be both positive and negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight

may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

Several x-rays taken in connection with the Miner's treatment made no mention of pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). As all of the treatment x-rays demonstrated abnormalities, I do not find them to be negative.

Dr. Bowles, in his report submitted in connection with the claim, referred to x-rays showing pneumoconiosis. He did not identify which x-rays he was referring to. Hence his opinion cannot be considered to be documented on this point.

There were four x-rays read in connection with the claim. The first, taken October 23, 2001, was read as positive by Dr. Ahmed, who is dually qualified. There were no negative readings.[8] I find this x-ray to be positive.

The x-ray taken on November 13, 2001, was read as positive by Dr. Baker, a B reader, and negative by Dr. Wiot, who is dually qualified. Based on Dr. Wiot's greater qualifications, I find this x-ray to be negative.

The x-ray taken on November 13, 2001, was read as positive by Dr. Miller, and negative by Dr. Wiot. As both are dually qualified, I find this x-ray to be in equipoise.

The x-ray taken on February 25, 2002, was read as negative by two readers. There are no positive readings. I find this x-ray to be negative. I note, however, that Dr. Wiot classified this x-ray as 0/1, which, while insufficient to establish the existence of pneumoconiosis, suggests that he considered the possibility that it was present.

Of the four x-rays, one was positive, one was in equipoise, and two were negative. All four were taken between October 2001, and February 2002, within four months of each other. Thus they were essentially contemporaneous. I find that while the readings do not establish pneumoconiosis under § 718.202(a)(1), they do not disprove it either.

I must next consider the medical opinions. The Claimant can establish that the Miner suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion

[8] As noted above, the Employer listed a reading of this x-ray by Dr. Dahhan in its Evidence Summary Forms, but no such reading could be found in the file. Even if there were a negative reading by Dr. Dahhan, however, I would still find this x-ray to be positive based on Dr. Ahmed's more extensive qualifications.

is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the [Miner's] treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that,

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

The earliest diagnosis of pneumoconiosis in the record is that of a nurse practitioner in 1995. That opinion carries little weight, as does the later opinion of Ms. Brooks, also a nurse practitioner, in view of their lesser qualifications than the physicians who have offered opinions.

The Miner's treating physicians generally reported that the Miner had both coal workers' pneumoconiosis and COPD. However, I cannot determine from the treatment records the basis for their opinions. Moreover, his treating pulmonologist, Dr. Crater, diagnosed severe emphysema, but did not mention pneumoconiosis, or attribute his emphysema to any particular cause. By February 2003, the Miner was using supplemental oxygen at night, *see* CX 2, but I cannot determine when it was first prescribed. Another pulmonologist, Dr. Dryzer, treated the Miner for an exacerbation of his COPD when he was hospitalized in March 2003, but reported only a "history of coal workers' pneumoconiosis." The CT scan he ordered was interpreted to show COPD, but again, did not mention pneumoconiosis. The severity of the Miner's COPD is apparent from his pulmonary function tests, need for supplemental oxygen and recurrent

exacerbations. However, I cannot give controlling weight to the diagnosis of pneumoconiosis by the treating physicians who mentioned it as one of his diagnoses, because they have not documented the basis for their opinions, or explained their reasoning.

In connection with the claim for benefits, in addition to the pathologists' opinions, there are five additional medical opinions addressing the presence of pneumoconiosis, by Drs. Baker, Dahhan, Bowles, Pietragallo, and Fino.

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Medical opinions which are based on the premise that coal dust-related obstructive disease is completely distinct from smoking-related disease, or that it is never clinically significant, are therefore contrary to the premises underlying the regulations. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

Dr. Dyer, the pathologist who conducted the autopsy, diagnosed clinical pneumoconiosis and emphysema. However, he did not address whether coal dust contributed to the Miner's emphysema. Thus he did not comment on whether legal pneumoconiosis was present. Similarly, Dr. Bowles, the Miner's urologist, did not address legal pneumoconiosis.

Dr. Baker based his opinion that the Miner had pneumoconiosis on a positive chest x-ray, the Miner's medical history and examination, pulmonary function studies, and arterial blood gas studies. He found both clinical and legal pneumoconiosis to be present, as he diagnosed clinical pneumoconiosis by x-ray, and legal pneumoconiosis based on his view that both smoking and coal dust exposure contributed to the Miner's obstructive disease. Dr. Baker provided adequate reasoning and documentation to support his opinion. Thus, I find his opinion well-documented and well-reasoned, and accord it probative weight on the issue of both clinical and legal pneumoconiosis. I have found the x-ray he relied upon to be negative, which undermines Dr. Baker's diagnosis of clinical pneumoconiosis. Nonetheless, the autopsy later proved him to be right on that account. I also give probative weight to his diagnosis of legal pneumoconiosis.

Dr. Dahhan based his opinion that the Miner did not have pneumoconiosis on a negative chest x-ray, the Miner's medical history and examination, negative x-ray, pulmonary function

studies, and arterial blood gas studies. He, too, provided adequate reasoning and documentation to support his opinion, at least in so far as he found no clinical pneumoconiosis. Thus I find his opinion as to the absence of clinical pneumoconiosis to be documented and reasoned. However, the autopsy proved him wrong on the issue of clinical pneumoconiosis. Moreover, Dr. Dahhan offered no sufficient reason for excluding coal dust exposure as a contributing factor to the Miner's obstructive disease. His statement that the obstructive defect could not be caused by inhalation of coal dust since the Miner had left the mines for over a year suggests that Dr. Dahhan does not accept that pneumoconiosis is a latent and progressive disease. His allusion to the reversibility of the Miner's obstruction with the administration of bronchodilators fails to acknowledge that the Miner's obstruction was only partially reversible. As Dr. Dahhan has offered no persuasive reason for discounting the role of coal dust in the Miner's obstructive disease, I find that Dr. Dahhan's opinion on the presence of legal pneumoconiosis is entitled to less weight than Dr. Baker's.

Dr. Tomashefski diagnosed clinical pneumoconiosis, while Dr. Pietragallo's opinion did not address the presence or absence of clinical pneumoconiosis. However, both stated that the Miners' chronic obstructive lung disease was related to cigarette smoking rather than pneumoconiosis. By way of explanation, Dr. Tomashefski said only that emphysema was present "well beyond the few pneumoconiotic lesions." I find that to be an inadequate explanation for him to rule out coal dust as a contributor to the Miner's emphysema. Dr. Pietragallo offered no explanation for that conclusion, and I find it to be unreasoned.

Finally, Dr. Fino did not directly acknowledge that the Miner had either clinical or legal pneumoconiosis. Rather he stated that he did not believe that any reduction in the FEV_1 due to coal dust inhalation caused or contributed to the Miner's disability; that the Miner's disabling lung disease was not related to coal mine dust, but was related to smoking; and, "assuming" the presence of simple clinical pneumoconiosis based on Dr. Dyer's autopsy report, it did not play a clinically significant role in the Miner's disability. He offered no explanation why he excluded coal dust as a contributing cause to the Miner's disabling obstructive disease. I find his opinion on this issue to be less than objective, and unreasoned.

I find that the Claimant has established that the Miner had both clinical and legal pneumoconiosis based on the autopsy, and the opinion of Dr. Baker.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Miner was employed as a miner for at least 30 years, and therefore is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that the Miner had both legal and clinical pneumoconiosis. I also find that she has established a causal relationship between his disease and his coal mine employment through the opinion of Dr. Baker.

Death Due to Pneumoconiosis

In claims filed after January 1, 1982, death will be considered to be due to pneumoconiosis if (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) the presumption set forth at 20 CFR § 718.304 applies, i.e., an irrebuttable presumption that death was due to pneumoconiosis where there is medical evidence of complicated pneumoconiosis; but not if (4) the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 CFR § 718.205(c) (2006). The Sixth Circuit, in which this claim arises, has held that any condition that hastens the miner's death is a substantially contributing cause of death. *Brown v. Rock Creek Mining Corp*., 996 F.2d 812 (6th Cir. 1993). This principle has now been codified in the regulations at 20 CFR § 718.205(c)(5) (2006). Nevertheless, a claimant must still prove that pneumoconiosis has "hastened" death by a "a specifically defined process that reduces the miner's life by an estimable time"; the basis for finding that pneumoconiosis contributed to a miner's death may not be simply that the disease made a miner weaker and, thus, less resistant to some other trauma that directly caused the death. *Eastover Mining v. Williams*, 338 F.3d 501, 517-518 (6th Cir. 2003).

The Death Certificate completed by Dr. Foster identified COPD and black lung as significant conditions contributing to the Miner's death. Reviewing again the medical opinions addressing the cause of the Miner's death, I note that Dr. Dyer did not state what role, if any, the Miner's lung disease played in his death. Dr. Bowles said that he could not perform surgery because of the Miner's lung disease, and that "at least in part his pneumoconiosis contributed to his death by reducing his lung function and not permitting us to proceed with possible curative therapy for his bladder carcinoma." In rebuttal, Dr. Pietragallo said that the Miner "would very probably, with greater than 85 percent likelihood, have died of metastatic bladder cancer even if bladder surgery could have been performed." Dr. Fino agreed that it was too speculative to say the Miner would not have developed metastatic cancer had he undergone surgery. I find that the evidence regarding the efficacy of surgery was insufficient to establish the contributory role of the condition of the Miner's lungs to his death.

On the other hand, both Dr. Fino and Dr. Tomashefski said that the Miner's clinical pneumoconiosis was not a contributing factor, but they agreed that his severe emphysema was a significant contributing factor to the Miner's death. There is no evidence contradicting their view on this point. As I have found that the Miner's emphysema was due to coal dust exposure as well as smoking, I find that the opinions of Drs. Fino and Tomashefski support the conclusion that the Miner's legal pneumoconiosis was a substantially contributing cause of death. For this reason, I find that the Claimant has established that the Miner's death was due to pneumoconiosis within the meaning of the statute and regulations.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met her burden to establish that the Miner died due to pneumoconiosis which arose out of coal mine employment, and is therefore entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The regulations address non-attorney representatives' fees at 20 CFR §§ 725.362, 365 and 366 (2006). The Claimant's representative has not yet filed an application for fees. The Claimant's representative is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties (including the Claimant) have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on September 12, 2003, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).